MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
UNIT OF EMERGENCY MEDICAL SERVICES

TRAINING ENTITY EMT-B SKILLS VERIFICATION

FOR DOH OFFICE USE ONLY-DO NOT WRITE IN THIS SPACE

TRAINING ENTITY ACCRED NO. ☐☐☐☐☐☐ DATE FORM RECEIVED ☐☐ ☐☐ ☐☐ DATE FORM RECEIVED ☐☐ ☐☐ ☐☐

APPLICANT MUST COMPLETE INFORMATION BELOW

TRADE NAME OF TRAINING ENTITY	**DAYTIME TELEPHONE NO.**
TRAINING ENTITY BUSINESS ADDRESS *(STREET, ROUTE, CITY, STATE, ZIP)*	

2. PROGRAM DIRECTOR

NAME *(LAST, FIRST, MI)*	TELEPHONE NUMBER
MAILING ADDRESS *(STREET, ROUTE, PO BOX, ETC)*	FAX NUMBER
CITY STATE ZIP CODE	E-MAIL

3. STATEMENT OF COMPETENCY IN EMT-BASIC SKILLS

As the EMT-Basic Training Program Director, I verify that the students listed have been examined and performed satisfactorily so as to be deemed competent in each of the following skills:

Patient Assessment/Management - Trauma	Mouth-to-Mask with Supplemental Oxygen
Patient Assessment/Management - Medical	Spinal Immobilization Supine Patient
Cardiac Arrest Management/AED	Spinal Immobilization Seated Patient
Bleeding Control/Shock Management	Long Bone Immobilization
Bag-Valve-Mask Apneic Patient	Joint Dislocation Immobilization
Supplemental Oxygen Administration	Traction Splinting
Upper Airway Adjuncts and Suction	Basic Ventilatory Management EOA or Dual Lumen

I HEREBY CERTIFY that this application contains no misrepresentation or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named training entity has both the intention and the ability to comply with the regulations promulgated under the Comprehensive EMS Act, Chapter 190, RSMo 2000.

SIGNATURE OF PROGRAM DIRECTOR	**DATE**

WARNING: In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. Missouri Statutes 575.060

Mail form to: Unit of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102

(06-04)

STUDENT NAME

MUST BE TYPEWRITTEN ALPHABETICALLY

List student's last name first

Last Name: First Name:	Last Name: First Name:

SIGNATURE OF PROGRAM DIRECTOR	DATE